DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington

To: DME Providers
Pharmacists
Home Health Agencies
Managed Care Plans
Regional Administrators
CSO Administrators

Memorandum No.: 02-80 MAA
Issued: October 11, 2002

For More Information, call:
1-800-562-6188

From: Douglas Porter, Assistant Secretary
Medical Assistance Administration

Subject: **Updates to the Wheelchairs, Durable Medical Equipment, and Supplies Billing Instructions**

The purpose of this memorandum is to provide providers with updates to billing instructions due to revisions to WAC 388-543-1000, 1100, 1300, and 2200. Please note changes in billing policy/procedures for rental equipment, utilization of valid ICD-9-CM diagnosis codes, and changes in the definitions of terms used.

What are the updates?

Billing Policy/Procedure Changes

Effective for dates of service on and after November 1, 2002:

- The Medical Assistance Administration (MAA) revised the rules (WAC) regarding Speech Generating Device (SGD) formerly known as Augmentative Communication Devices.
- From/to dates of service will be required on all rental billings.
- MAA will require valid ICD-9-CM codes on all billings. MAA will no longer allow the use of unspecified diagnosis codes such as V58.9.
- Written requests for prior authorization must be submitted to MAA on a HCFA-1500 claim form with the date of service left blank and a copy of the prescription attached.

Definition Changes

- MAA added a definition for "Speech Generating Device (SGD) and updated the definitions for "Augmentative Communication Device," "Fee-for-Service, " and "Limitation Extension."

Attached are replacement pages A.1-A.6, D.1-D.10, G.3-G.4, H.3-H.6, J.9-J.14, and L.3-L.8 for MAA's Wheelchairs, Durable Medical Equipment (DME), and Supplies Billing Instructions, dated September 2001, reflecting the WAC revisions.

To obtain MAA's Billing Instructions and/or Numbered Memorandums electronically, go to: http://maa.dshs.wa.gov (click on the Provider Publications/Fee Schedules link).

Definitions

This section defines terms, abbreviations, and acronyms used in this billing instruction.

Augmentative Communication Device (ACD) – See "speech generating device (SGD)." [WAC 388-543-1000]

Base Year – The year of the data source used in calculating prices. [WAC 388-543-1000]

By Report (BR) – A method of reimbursement for covered items, procedures, and services for which the department has no set maximum allowable fees.
[WAC 388-543-1000]

Client - An applicant for, or recipient of, DSHS medical care programs.

Code of Federal Regulations (CFR) - A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

Community Services Office (CSO) - An office of the department that administers social and health services at the community level. [WAC 388-500-0005]

Core Provider Agreement - The basic contract that MAA holds with providers serving MAA clients. The provider agreement outlines and defines terms of participation in Medical Assistance.

Date of Delivery – The date the client actually took physical possession of an item or equipment. [WAC 388-543-1000]

Department - The state Department of Social and Health Services [DSHS]. [WAC 388-500-0005]

Disposable Supplies – Supplies that may be used once, or more than once, but are time limited. [WAC 388-543-1000]

Durable Medical Equipment (DME) – Equipment that:

- Can withstand repeated use;
- Is primarily and customarily used to serve a medical purpose;
- Generally is not useful to a person in the absence of illness or injury; and
- Is appropriate for use in the client's place of residence.
  [WAC 388-543-1000]

Expedited Prior Authorization – The process for obtaining authorization for selected durable medical equipment, and related supplies, prosthetics, orthotics, medical supplies and related services, in which providers use a set of numeric codes to indicate to MAA which acceptable indications/conditions/MAA-defined criteria are applicable to a particular request for DME authorization. [WAC 388-543-1000]

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Explanation of Medicare Benefits (EOMB) – A federal report generated for Medicare providers displaying transaction information regarding Medicare claims processing and payments.

Fee-for-Service – The general payment method MAA uses to reimburse for covered medical services provided to clients, except those services covered under MAA's prepaid managed care programs.
[WAC 388-543-1000]

Health Care Financing Administration Common Procedure Coding System (HCPCS) – A coding system established by the Health Care Financing Administration to define services and procedures.
[WAC 388-543-1000]

Healthy Options – The name of the Washington State, Medical Assistance Administration's managed care program.

House Wheelchair – A nursing facility wheelchair that is included in the nursing facility's per-patient-day rate under chapter 74.46 RCW. [WAC 388-543-1000]

Limitation Extension – A process for requesting and approving covered services and reimbursement that exceeds a coverage limitation (quantity, frequency, or duration) set in WAC, billing instructions, or numbered memoranda. Limitation extensions require prior authorization. [WAC 388-543-1000)]

Managed Care - A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services.
[WAC 388-538-050]

Manual Wheelchair – See "Wheelchair – Manual." [WAC 388-543-1000]

Maximum Allowable - The maximum dollar amount that MAA will reimburse a provider for specific services, supplies, and equipment.

Medicaid - The state and federally funded aid program that covers the Categorically Needy (CNP) and Medically Needy (MNP) programs.

Medical Assistance Administration (MAA) - The administration within DSHS authorized by the secretary to administer the acute care portion of the Title XIX Medicaid, Title XXI Children's Health Insurance Program (CHIP), and the state-funded medical care programs, with the exception of certain non-medical services for persons with chronic disabilities.

Medical Identification card(s) – Medical Identification cards are the forms DSHS uses to identify clients of medical programs. These cards are good only for the dates printed on them. Clients will receive a Medical Identification card in the mail each month they are eligible. These cards are also known as DSHS Medical ID cards and were formerly called medical coupons or MAID cards.

Medically Necessary - A term for describing [a] requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. [WAC 388-500-0005]

Medical Supplies – Supplies that are:

- Primarily and customarily used to service a medical purpose; and
- Generally not useful to a person in the absence of illness or injury. [WAC 388-543-1000]

Medicare - The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare. [WAC 388-500-0005]

Nonreusable Supplies – Supplies that are used only once and then are disposed of. [WAC 388-543-1000]

Other DME – All durable medical equipment, excluding wheelchairs and related items.

Orthotic Device or Orthotic – A corrective or supportive device that:

- Prevents or corrects physical deformity or malfunction; or
- Supports a weak or deformed portion of the body. [WAC 388-543-1000]

Patient Identification Code (PIC) - An alphanumeric code that is assigned to each MAA client consisting of:

- First and middle initials (a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birthdate, consisting of numerals only (MMDDYY).
- First five letters of the last name (and spaces if the name is fewer than five letters).
- Alpha or numeric character (tiebreaker).

Personal or Comfort Item – An item or service that primarily serves the comfort or convenience of the client. [WAC 388-543-1000]

Personal Computer – Any of a variety of electronic devices that are capable of accepting data and instructions, executing the instructions to process the data, and presenting the results. A PC has a central processing unit (CPU), internal and external memory storage, and various input/output devices such as a keyboard, display screen, and printer. A computer system consists of hardware (the physical components of the system) and software (the programs used by the computer to carry out its operations). [WAC 388-543-1000]

Plan of Care (POC) – (Also known as "plan of treatment" [POT]) A written plan of care that is established and periodically reviewed and signed by both a physician and a home health agency provider, that describes the home health care to be provided at the client's residence. [WAC 388-551-2010]

Power-Drive Wheelchair – See "Wheelchair – Power." [WAC 388-543-1000]

Program Support, Division of (DPS) – The division within MAA responsible for providing administrative services for the following:

- Claims Processing;
- Family Planning Services;
- Administrative Match Services to Schools and Health Departments;
- Managed Care Contracts; and
- Provider Enrollment/Relations.

Prosthetic Device or Prosthetic – A replacement, corrective, or supportive device prescribed by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice as defined by state law, to:

- Artificially replace a missing portion of the body;
- Prevent or correct physical deformity or malfunction; or
- Support a weak or deformed portion of the body. [WAC 388-543-1000]

Provider or Provider of Service - An institution, agency, or person:

- Who has a signed agreement [Core Provider Agreement] with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department. [WAC 388-500-0005]

Remittance and Status Report (RA) - A report produced by the claims processing system in the Division of Program Support, Medical Assistance Administration that provides detailed information concerning submitted claims and other financial transactions.

Resource Based Relative Value Scale (RBRVS) – A scale that measures the relative value of a medical service or intervention, based on amount of physician resources involved. [WAC 388-543-1000]

Reusable Supplies – Supplies that are to be used more than once. [WAC 388-543-1000]

Revised Code of Washington (RCW) - Washington State laws.

Scooter – A federally-approved, motor-powered vehicle that:

- Has a seat on a long platform;
- Moves on either three or four wheels;
- Is controlled by a steering handle; and
- Can be independently driven by a client. [WAC 388-543-1000]

Specialty bed – A pressure reducing support surface, such as foam, air, water, or gel mattress or overlay. [WAC 388-543-1000]

Speech generating device (SGD) - An electronic device or system that compensates for the loss or impairment of a speech function due to a congenital condition, an acquired disability, or a progressive neurological disease. The term includes only that equipment used for the purpose of communication. Formerly known as "augmentative communication device (ACD)."

Third Party - Any entity that is or may be liable to pay all or part of the medical cost of care of a federal Medicaid or state medical program client. [WAC 388-500-0005]

Three- or Four-wheeled Scooter – A three- or four-wheeled vehicle meeting the definition of scooter (see "scooter") and that has the following minimum features:

- Rear drive;
- A twenty-four volt system;
- Electronic or dynamic braking;
- A high to low speed setting; and
- Tires designed for indoor/outdoor use. [WAC 388-543-1000]

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.

Trendelenburg Position – A position in which the patient is lying on his or her back on a plane inclined thirty to forty degrees. This position makes the pelvis higher than the head, with the knees flexed and the legs and feet hanging down over the edge of the plane. [WAC 388-543-1000]

Usual and Customary Charge – The amount the provider typically charges to 50% or more of his or her non-Medicaid clients, including clients with other third-party coverage. [WAC 388-543-1000]

Warranty-wheelchair – A warranty, according to manufacturers' guidelines, of not less than one year from the date of purchase. [WAC 388-543-1000]

Wheelchair-manual – A federally-approved, nonmotorized wheelchair that is capable of being independently propelled and fits one of the following categories:

1) Standard:

   a) Usually is not capable of being modified;
   b) Accommodates a person weighing up to two hundred fifty pounds; and
   c) Has a warranty period of at least one year.

2) Lightweight:

   a) Composed of lightweight materials;
   b) Capable of being modified;
   c) Accommodates a person weighing up to two hundred fifty pounds; and
   d) Usually has a warranty period of at least three years.

3) High strength lightweight:

   a) Is usually made of a composite material;
   b) Is capable of being modified;
   c) Accommodates a person weighing up to two hundred fifty pounds;
   d) Has an extended warranty period of over three years; and
   e) Accommodates the very active person.

4) Hemi:

   a) Has a seat-to-floor height lower than eighteen inches to enable an adult to propel the wheelchair with one or both feet: and
   b) Is identified by its manufacturer as "Hemi" type with specific model numbers that include the "Hemi" description.

5) Pediatric: Has a narrower seat and shorter depth more suited to pediatric patients, usually adaptable to modifications for a growing child.

6) Recliner: Has an adjustable, reclining back to facilitate weight shifts and provide support to the upper body and head.

7) Tilt-in-space: Has a positioning system, that allows both the seat and back to tilt to a specified angle to reduce shear or allow for unassisted pressure releases.

8) Heavy Duty:

   a) Specifically manufactured to support a person weighing up to three hundred pounds; or
   b) Accommodating a seat width of up to twenty-two inches wide (not to be confused with custom manufactured wheelchairs).

9) Rigid: Is of ultra-lightweight material with a rigid (nonfolding) frame.

10) Custom Heavy Duty:

   a) Specifically manufactured to support a person weighing over three hundred pounds; or
   b) Accommodates a seat width of over twenty-two inches wide (not to be confused with custom manufactured wheelchairs).

11) Custom Manufactured Specially Built:

   a) Ordered for a specific client from custom measurements; and
   b) Is assembled primarily at the manufacturer's factory.

[WAC 388-543-1000]

Wheelchair–power – A federally-approved, motorized wheelchair that can be independently driven by a client and fits one of the following categories:

1) Custom power adaptable to:

   a) Alternative driving controls; and
   b) Power recline and tilt-in-space systems.

2) Noncustom power: Does not need special positioning or controls and has a standard frame.

3) Pediatric: Has a narrower seat and shorter depth that is more suited to pediatric patients. Pediatric wheelchairs are usually adaptable to modifications for a growing child.
[WAC 388-543-1000]

Washington Administrative Code (WAC) - Codified rules of the state of Washington.

Coverage

What is covered? [Refer to WAC 388-543-1100]

The Medical Assistance Administration (MAA) covers the following subject to the provisions of this billing instruction:

- Wheelchairs and other DME;
- Equipment and supplies prescribed in accordance with an approved plan of treatment under the home health program;
- Orthotic Devices;
- Equipment and supplies for the management of diabetes;
- Replacement batteries (for covered, purchased, medically necessary DME equipment); and
- Bilirubin lights (limited to rentals for at-home newborns with jaundice).

What are the general conditions of coverage?

MAA covers the services listed above when all of the following apply. They must be:

- Medically necessary (see *Definitions* section). The provider or client must submit sufficient objective evidence to establish medical necessity. Information used to establish medical necessity includes, but is not limited to, the following:
  - ✓ A physiological description of the client's disease, injury, impairment, or other ailment, and any changes in the client's condition written by the prescribing physician, licensed prosthetist and/or orthotist, physical therapist, occupational therapist, or speech therapist; or
  - ✓ Video and/or photograph(s) of the client demonstrating the impairments and the client's ability to use the requested equipment, when applicable.
- Within the scope of an eligible client's medical care program (see *Client Eligibility* section);
- Within accepted medical or physical medicine community standards of practice;

- Prior authorized (see *Prior Authorization* section);

- Prescribed by a physician or other licensed practitioner of the healing arts and are within the scope of his or her practice as defined by state law. The prescription must state the specific item or service requested, diagnosis, prognosis, estimated length of need (weeks or months, not to exceed six months before being reevaluated), and quantity; and

- Billed to the department as the payer of last resort only. MAA does not pay first and then collect from Medicare.

See the *Wheelchair Fee Schedule* and *Other DME Fee Schedule* sections (I and J) for a complete list of covered medical equipment and related supplies, repairs, and labor charges.

Note: The evaluation of a By Report (BR) item, procedure, or service for its medical appropriateness and reimbursement value on a case-by-case basis.

What are other specific conditions of coverage?

Clients Residing in a Nursing Facility

- MAA covers the following for a client in a nursing facility:

  ✓ The purchase and repair of:

  - A speech generating device (SGD);
  - A wheelchair for the exclusive full-time use of a permanently disabled nursing facility resident when the wheelchair is not included in the nursing facility's per diem rate; or
  - A specialty bed; and
  - The rental of a specialty bed.

  ✓ All other DME and supplies identified in this billing instruction are the responsibility of the nursing facility, in accordance with chapters 388-96 and 388-97 WAC.

Speech Generating Devices (SGD) [WAC 388-543-2200]

- MAA considers all requests for SGDs on a case-by-case basis.

- The SGD requested must be for a severe expressive speech impairment, and the medical condition must warrant the use of a device to replace verbal communication (e.g., to communicate medical information).

- In order for MAA to cover an SGD, the SGD must be a speech device intended for use by the individual who has a severe expressive speech impairment and have one of the following characteristics. For the purposes of these billing instructions, MAA uses the Medicare definitions for "digitized speech" and "synthesized speech" that were in effect as of April 1, 2002. The SGD must have:

  - ✓ Digitized speech output, using pre-recorded messages;
  - ✓ Synthesized speech output requiring message formation by spelling and access by physical contact with the device; or
  - ✓ Synthesized speech output, permitting multiple methods of message formulation and multiple methods of device access.

- MAA requires a provider to submit a prior authorization request for SGDs. The request must be in writing and contain all of the following information:

  - ✓ A detailed description of the client's therapeutic history; including, at a minimum:

    - ➢ The medical diagnosis;
    - ➢ A physiological description of the underlying disorder;
    - ➢ A description of the functional limitations; and
    - ➢ The prognosis for improvement or degeneration.

  - ✓ A written assessment by a licensed speech language pathologist (SLP) that includes all of the following:

    - ➢ If the client has a physical disability, condition, or impairment that requires equipment, such as a wheelchair, or a device to be specially adapted to accommodate an SGD, and an assessment by the prescribing physician, licensed occupational therapist, or physical therapist;

    - ➢ Documented evaluations and/or trials of each SGD that the client has tried. This includes less costly types/models, and the effectiveness of each device in promoting the client's ability to communicate with health care providers, caregivers, and others;

    - ➢ The current communication impairment, including the type, severity, language skills, cognitive ability, and anticipated course of the impairment;

- An assessment of whether the client's daily communication needs could be met using other natural modes of communication;
- A description of the functional communication goals expected to be achieved, and treatment options;
- Documentation that the client's speaking needs cannot be met using natural communication methods; and
- Documentation that other forms of treatment have been ruled out.

✓ The provider has shown or has demonstrated all of the following:

- The client has reliable and consistent motor response, which can be used to communicate with the help of an SGD;
- The client has demonstrated the cognitive and physical abilities to utilize the equipment effectively and independently to communicate; and
- The client's treatment plan includes a training schedule for the selected device.

✓ A prescription for the SGD from the client's treating physician.

- MAA may require trial-use rental. All rental costs for the trial-use will be applied to the purchase price.
- **MAA covers SGDs only once every two years for a client who meets the above listed criteria.** MAA does not approve a new or updated component, modification, or replacement model for a client whose SGD can be repaired or modified. MAA may make exceptions to the above criteria based strictly on a finding of unforeseeable and significant changes to the client's medical condition. The prescribing physician is responsible for justifying why the changes in the client's medical condition were unforeseeable.

Bathroom/Shower Equipment [WAC 388-543-2300]

- MAA considers a caster-style shower commode chair as the primary option for clients.
- MAA considers a wheelchair-style shower commode chair only if the client meets both of the following:
  - ✓ Is able to propel the equipment; and
  - ✓ Has special positioning needs that cannot be met by a caster-style chair.
- All other circumstances will be considered on a case-by-case basis, based on medical necessity.

Hospital Beds [WAC 388-543-2400]

- Beds covered by MAA are limited to hospital beds for rental or purchase. MAA bases the decision to rent or purchase a manual, semi-electric, or full electric hospital bed on the length of time the client needs the bed, as follows:
  - ✓ MAA initially authorizes a maximum of two months rental for a short-term need. Upon request, MAA may allow limitation extensions as medically necessary (see EPA criteria for hospital beds, page G.6 and G.7);
  - ✓ MAA determines rental on a month-to-month basis if a client's prognosis is poor;
  - ✓ MAA considers a purchase if the need is for more than six months;
  - ✓ If the client continues to have a medical need for a hospital bed after six months, MAA may approve rental for up to an additional six months. MAA considers the equipment to be purchased after a total of twelve months' rental.
- MAA considers a manual hospital bed the primary option when the client has full-time caregivers.

- MAA considers a full electric hospital bed only if the client meets all of the following criteria:

  ✓ The client's medical need requires the client to be positioned in a way that is not possible in a regular bed;

  ✓ The position cannot be attained through less costly alternatives (e.g., the use of bedside rails, a trapeze, pillows, bolsters, rolled up towels or blankets);

  ✓ The client's medical condition requires immediate position changes;

  ✓ The client is able to operate the controls independently; and

  ✓ The client needs to be in the Trendelenburg position.

- All other circumstances for hospital beds will be considered on a case-by-case basis, based on medical necessity. (See also EPA criteria in Section G.)

What if a service is covered but considered experimental or has restrictions or limitations? [WAC 388-543-1100 (3) and (4)]

- MAA evaluates a request for a service that is in a covered category, but has been determined to be experimental or investigational as defined by WAC 388-531-0050, under the provisions of WAC 388-501-0165 which relate to medical necessity.

- MAA evaluates a request for a covered service that is subject to limitations or other restrictions and approves such a service beyond those limitations or restrictions when medically necessary, under the standards for covered services in WAC 388-501-0165 (see page G.3 for limitation extensions).

How can I request that equipment/supplies be added to the "covered" list in this billing instruction? [WAC 388-543-1100 (7)]

An interested party may request MAA to include new equipment/supplies in these billing instructions by sending a written request to MAA's Quality Utilization Section (see *Important Contacts* section*)*, plus all of the following:

- Manufacturer's literature;
- Manufacturer's pricing;
- Clinical research/case studies (including FDA approval, if required); and
- Any additional information the requestor feels is important.

What is not covered? [Refer to WAC 388-543-1300]

MAA pays only for durable medical equipment (DME) and related supplies and services that are medically necessary, listed as covered, meet the definition of DME and medical supplies (see *Definitions* section), and prescribed per the provider requirements in this billing instruction (see *Provider Requirements* section).

MAA considers all requests for covered DME, related supplies and services, and noncovered equipment and related supplies, and services, under the provisions of WAC 388-501-0165 which relate to medical necessity. When MAA considers that a request does not meet the requirements for medical necessity, the definition(s) of covered item(s), or is not covered, the client may appeal that decision under the provisions of WAC 388-501-0165.

MAA specifically excludes services and equipment in this billing instruction from fee-for-service (FFS) scope of coverage when the services and equipment do not meet the definition for a covered item, or the services are not typically medically necessary. This exclusion does not apply if the services and equipment are:

- Requested for a child who is eligible for services under the EPSDT program;
- Included as part of a managed care plan service package;
- Included in a waivered program; or
- Part of one of the Medicare programs for qualified Medicare beneficiaries.

Services and equipment that are not covered include, but are not limited to:

- Services, procedures, devices, or the application of associated services that the department of the Food and Drug Administration (FDA) and/or the Centers for Medicare and Medicaid (CMS) (formerly known as HCFA) consider investigative or experimental on the date the services are provided;

- Any service specifically excluded by statute;

- More costly services or equipment when MAA determines that less costly, equally effective services or equipment are available;

- A client's utility bills, even if the operation or maintenance of medical equipment purchased or rented by MAA for the client contributes to an increased utility bill (refer to the Aging and Adult Services Administration (AASA) COPES program for potential coverage);

- Hairpieces or wigs;

- Material or services covered under manufacturer's warranties;

- Procedures, prosthetics, or supplies related to gender dysphoria surgery;
- Shoe lifts less than one inch, arch supports, and nonorthopedic shoes;

- Supplies and equipment used during a physician office visit, such as tongue depressors and surgical gloves;

- Prosthetic devices dispensed for cosmetic reasons;

- Home improvements and structural modifications, including, but not limited to, the following:

  - ✓ Automatic door openers for the house or garage;
  - ✓ Electrical rewiring for any reason;
  - ✓ Elevator systems, elevators;
  - ✓ Lifts or ramps for the home;
  - ✓ Saunas;
  - ✓ Security systems, burglar alarms, call buttons, lights, light dimmers, motion detectors, and similar devices;
  - ✓ Swimming pools; and
  - ✓ Whirlpool systems, such as Jacuzzis, hot tubs, or spas.

- Non-medical equipment, supplies, and related services, including but not limited to, the following:

  - ✓ Back-packs, pouches, bags, baskets, or other carrying containers;
  - ✓ Bedboards/conversion kits, and blanket lifters (e.g., for feet);
  - ✓ Car seats for children under five, except for positioning car seats that are prior authorized. Refer to "*Rented DME and Supplies*" for car seats;
  - ✓ Cleaning brushes and supplies, except for ostomy-related cleaners/supplies;
  - ✓ Diathermy machines used to produce heat by high frequency current, ultrasonic waves, or microwave radiation;
  - ✓ Electronic communication equipment, installation services, or service rates including, but not limited to, the following:

    - ➢ Devices intended for amplifying voices (e.g., microphones);

    - ➢ Interactive communications computer programs used between patients and healthcare providers (e.g., hospitals, physicians), for self care home monitoring, or emergency response systems and services (refer to AASA COPES or outpatient hospital programs for emergency response systems and services);

    - ➢ Two-way radios; and

    - ➢ Rental of related equipment or services;

- ✓ Environmental control devices, such as air conditioners, air cleaners/purifiers, dehumidifiers, portable room heaters or fans (including ceiling fans), heating or cooling pads;
- ✓ Ergonomic equipment;
- ✓ Exercise classes or equipment such as exercise mats, bicycles, tricycles, stair steppers, weights, or trampolines;
- ✓ Generators;
- ✓ Computer software other than speech generating, printers, and computer accessories (such as anti-glare shields, backup memory cards, etc.);
- ✓ Computer utility bills, telephone bills, Internet service, or technical support for computers or electronic notebooks;
- ✓ Any communication device that is useful to someone without severe speech impairment (e.g., cellular telephone, walkie-talkie, pager, or electronic notebook);
- ✓ Racing stroller/wheelchairs and purely recreational equipment;
- ✓ Room fresheners/deodorizers;
- ✓ Bidet or hygiene systems, paraffin bath units, and shampoo rings;
- ✓ Timers or electronic devices to turn things on or off, which are not an integral part of the equipment;
- ✓ Vacuum cleaners, carpet cleaners/deodorizers, and/or pesticides/insecticides; or
- ✓ Wheeled reclining chairs, lounge and/or lift chairs (e.g., geri-chair, posture guard, or lazy boy).

- Personal and comfort items that do not meet the DME definition, including, but not limited to, the following:

  - ✓ Bathroom items, such as antiperspirant, astringent, bath gel, conditioner, deodorant, moisturizers, mouthwash, powder, shampoo, shaving cream, shower cap, shower curtains, soap (including antibacterial soap), toothpaste, towels, and weight scales;
  - ✓ Bedding items, such as bed pads, blankets, mattress covers/bags, pillows, pillow cases/covers; and sheets;
  - ✓ Bedside items, such as bed trays, carafes, and over-the-bed tables;
  - ✓ Clothing and accessories, such as coats, gloves (including wheelchair gloves), hats, scarves, slippers, and socks;
  - ✓ Clothing protectors and other protective cloth furniture covering;
  - ✓ Cosmetics, including corrective formulations, hair depilatories, and products for skin bleaching, commercial sun screens, and tanning;
  - ✓ Diverter valves for bathtub;
  - ✓ Eating/feeding utensils;
  - ✓ Emesis basins, enema bags, and diaper wipes;
  - ✓ Health club memberships;
  - ✓ Hot or cold temperature food and drink containers/holders;
  - ✓ Hot water bottles and cold/hot packs or pads not otherwise covered by specialized therapy programs;
  - ✓ Impotence devices;

- ✓ Insect repellants;
- ✓ Massage equipment;
- ✓ Medication dispensers, such as med-collators and count-a-dose, except as obtained under the compliance packaging program. See Chapter 388-530 WAC;
- ✓ Medicine cabinet and first aid items, such as adhesive bandages (e.g., Band-Aids, Curads), cotton balls, cotton-tipped swabs, medicine cups, thermometers, and tongue depressors;
- ✓ Page turners;
- ✓ Radios and televisions;
- ✓ Telephones, telephone arms, cellular phones, electronic beepers, and other telephone messaging services; and
- ✓ Toothettes and toothbrushes, waterpics, and peridontal devices whether manual, battery-operated, or electric.

- Certain wheelchair features and options are not considered by MAA to be medically necessary or essential for wheelchair use. This includes, but is not limited to, the following:

  - ✓ Attendant controls (remote control devices);
  - ✓ Canopies, including those for stroller and other equipment;
  - ✓ Clothing guards to protect clothing from dirt, mud, or water thrown up by the wheels (similar to mud flap for cars);
  - ✓ Identification devices (such as labels, license plates, name plates);
  - ✓ Lighting systems;
  - ✓ Speed conversion kits;
  - ✓ Tie-down restraints, except where medically necessary for client owned vehicles; and
  - ✓ Warning devices, such as horns and backup signals.

☞ **Note:** MAA evaluates a request for any equipment or devices that are listed as noncovered in this billing instruction under the provisions of WAC 388-501-0165. (Refer to WAC 388-543-1100[2])

- MAA does not reimburse for purchase, rental, or repair of medical equipment that duplicates equipment the client already owns or rents. If the requesting provider makes such a request, MAA requires the provider to submit for PA and explain the following:

  ✓ Why the existing equipment no longer meets the client's medical needs; or
  ✓ Why the existing equipment could not be repaired or modified to meet those medical needs.

- A provider may resubmit a request for PA for an item or service that MAA has denied. MAA requires the provider to include new documentation that is relevant to the request.

- MAA authorizes rental equipment for a specific period of time. The provider must request authorization from MAA for any extension of the rental period.

☞ **Note:** Written requests for prior authorization must be submitted to MAA on a HCFA-1500 claim form with the date of service left blank and a copy of the prescription attached.

What is a Limitation Extension?

A limitation extension is when MAA allows additional units of service for a client when the provider can verify that the additional units of service are medically necessary. Limitation extensions require authorization.

☞ **Note:** Requests for limitation extensions must be appropriate to the client's eligibility and/or program limitations. Not all eligibility groups cover all services.

How do I request a limitation extension?

In cases where the provider feels that additional services are still medically necessary for the client, the provider must request MAA-approval in writing.

The request must state the following in writing:

1. The name and PIC number of the client;
2. The provider's name, provider number and fax number;
3. Additional service(s) requested;
4. Copy of last prescription and date dispensed;
5. The primary diagnosis code and HCPCS code or state assigned code; and
6. Client-specific clinical justification for additional services.

Send your written request for a limitation extension to:

Write/Call:
Division of Medical Management
Quality Utilization Section
Durable Medical Equipment
PO Box 45506
Olympia, WA 98504-5506
(800) 292-8064
(360) 586-5299 (fax)

What is expedited prior authorization?

The expedited prior authorization process (EPA) is designed to eliminate the need for written and telephonic requests for prior authorization for selected durable medical equipment (DME) procedure codes. MAA allows payment during a continuous 12-month period for this process.

To bill MAA for DME that meet the EPA criteria on the following pages, the vendor must create a 9-digit EPA number. The first 6 digits of the EPA number must be **870000.** The last 3 digits must be the code number of the product and documented medical condition that meets the EPA criteria. Enter the EPA number on the HCFA-1500 claim form in the ***Authorization Number*** field or in the ***Authorization*** or ***Comments*** field when billing electronically.

Example: The 9-digit EPA number for rental of a semi-electric hospital bed for a client that meets all of the EPA criteria would be **870000725** (870000 = first 6 digits, 725 = product and documented medical condition).

Vendors are reminded that EPA numbers are only for those products listed <u>on the following pages.</u> EPA numbers are not valid for:

- Other DME requiring prior authorization through the DME program;
- Products for which the documented medical condition does not meet <u>all</u> of the specified criteria; or
- Over-limitation requests.

The written or telephonic request for prior authorization process must be used when a situation does not meet the criteria for a selected DME code, or a requested rental exceeds the limited rental period indicated. Providers must submit the request in writing to Quality Utilization or call the authorization toll-free number at 1-800-292-8064. (See *Important Contacts* section.) (WAC 388-543-1900[3])

- MAA charges the dispensing provider for any costs it incurs to have another provider repair equipment if all of the following apply:

  - ✓ Any DME that MAA considers purchased according to these billing instructions (see "*Rented DME and Supplies"* in section H) requires repair during the applicable warranty period;

  - ✓ The dispensing provider is unwilling or unable to fulfill the warranty; and

  - ✓ The client still needs the equipment.

- MAA rescinds purchase orders for the following reasons:

  - ✓ If the equipment was not delivered to the client before the client:

    - ➢ Dies;
    - ➢ Loses medical eligibility;
    - ➢ Becomes covered by a hospice agency; or
    - ➢ Becomes covered by an MAA managed care plan.

  - ✓ A provider may incur extra costs for customized equipment that may not be easily resold. In these cases, for purchase orders rescinded per the stipulations listed above, MAA may pay the provider an amount it considers appropriate to help defray these extra costs. MAA requires the provider to submit justification sufficient to support such a claim.

  - ✓ A client may become a managed care plan client before MAA completes the purchase of prescribed medical equipment. If this occurs:

    - ➢ MAA rescinds the purchase order until the managed care primary care provider (PCP) evaluates the client; then

    - ➢ MAA requires the PCP to write a new prescription if the PCP determines the equipment is still medically necessary (see *Definitions* section); then

    - ➢ The managed care plan's applicable reimbursement policies apply to the purchase or rental of the equipment.

Rented DME and Related Supplies [WAC 388-543-1700]

- MAA's reimbursement amount for rented DME includes all of the following:

  - ✓ Delivery to the client;
  - ✓ Fitting, set-up, and adjustments;
  - ✓ Maintenance, repair and/or replacement of the equipment; and
  - ✓ Return pickup by the provider.

- MAA requires a dispensing provider to ensure the DME rented to an MAA client is both of the following:

  - ✓ In good working order; and

  - ✓ Comparable to equipment the provider rents to clients with similar medical equipment needs who are either private pay clients or who have other third-party coverage.

- MAA considers rented equipment to be purchased after 12 months' rental unless one of the following apply:

  - ✓ The equipment is restricted as rental only; or
  - ✓ Other MAA published issuances state otherwise.

- MAA rents, but does not purchase, certain medically necessary equipment for clients. This includes, but is not limited to, the following:

  - ✓ Bilirubin lights for newborns at home with jaundice; and
  - ✓ Electric breast pumps.

- MAA's minimum rental period for covered DME is one day.

- MAA requires that both the begin date and the end date of a rental segment be indicated on the HCFA-1500 claim form in the "dates of service," "from," and "to" areas for all rental billings.

- If a fee-for-service (FFS) client becomes a managed care plan client, both of the following apply:

  - ✓ MAA stops paying for any rented equipment on the last day of the month preceding the month in which the client becomes enrolled in the managed care plan; and

  - ✓ The plan determines the client's continuing need for the equipment and is responsible for reimbursing the provider.

- MAA stops paying for any rented equipment effective the date of a client's death. MAA prorates monthly rental as appropriate.

- For a client who is eligible for both Medicaid and Medicare, MAA pays only the client's coinsurance and deductibles for rental equipment when either of the following applies:

  - ✓ The reimbursement amount reaches Medicare's reimbursement cap for the equipment; or

  - ✓ Medicare considers the equipment purchased.

- MAA does not obtain or pay for insurance coverage against liability, loss and/or damage to rental equipment that a provider supplies to an MAA client.

When does MAA not reimburse under fee-for-service?

[WAC 388-543-1100 (5)]

MAA does not reimburse for DME and related supplies and repairs and labor charges under fee-for-service (FFS) when the client is any of the following:

- An inpatient hospital client;
- Eligible for both Medicare and Medicaid, and is staying in a nursing facility in lieu of hospitalization;
- Terminally ill and receiving hospice care; or
- Enrolled in a risk-based managed care plan that includes coverage for such items and/or services.

DME and Supplies Provided in Physician's Office

MAA does not pay a DME provider for medical supplies used in conjunction with a physician office visit. MAA pays the office physician for these supplies, as stated in the Resource Based Relative Value Scale (RBRVS), when it is appropriate.

Warranty

- MAA requires providers to:

  - ✓ Furnish to MAA clients only new equipment that includes full manufacturer and dealer warranties; and
  - ✓ Include a warranty on equipment for one year after the date MAA considers rented equipment to be purchased as provided in this billing instruction (see "*Rented DME and Supplies"* in section H). (Refer to WAC 388-543-1500[3][4])

- MAA charges the dispensing provider 50% of the total amount MAA paid toward rental and eventual purchase of the first equipment if the rental equipment must be replaced during the warranty period. All of the following must apply:

  - ✓ Any medical equipment that MAA considers purchased according to this billing instruction (see "*Rented DME and Supplies"* in section H) requires replacement during the applicable warranty period;

  - ✓ The dispensing provider is unwilling or unable to fulfill the warranty; and

  - ✓ The client still needs the equipment.

MINIMUM WARRANTY PERIODS	
Wheelchair Frames (Purchased New) and Wheelchair Parts	**Warranty**
Powerdrive *(depending on model)* Ultralight Active Duty Lightweight *(depending on model)* All Others	1 year - lifetime lifetime 5 years - lifetime 1 year
Electrical Components	**Warranty**
All electrical components whether new or replacement parts including batteries	6 months - 1 year
Other DME	**Warranty**
All other DME not specified above (excludes disposable/ non-reusable supplies)	1 year

Procedure Code	Description	Rental (RR)	Purchase (1P)
0904E	Adjustable standing frame. Includes 2 padded back support blocks, chest strap, pelvic strap, pair of knee blocks, abductor and foot blocks (for child/adult 30"-68" tall). **Limit of one per client every 5 years. Purchase only.**		$1,100.00
0366E	Abductor wedge for prone stander for youth/adult up to 75" tall. Included in nursing facility daily rate. **Purchase only**.		$95.70
0367E	Tray for all positioning equipment, any size. Included in nursing facility daily rate. **Purchase only**.		$266.86

Noninvasive Bone Growth/Nerve Stimulators

Procedure Code	Description	Rental (RR)	Purchase (1P)
E0730	***Removed. Please refer to MAA's Nondurable Medical Supplies and Equipment (MSE) Billing Instructions.***		
0116E	***Removed. Please refer to MAA's Nondurable Medical Supplies and Equipment (MSE) Billing Instructions.***		
0118E	***Removed. Please refer to MAA's Nondurable Medical Supplies and Equipment (MSE) Billing Instructions.***		
0119E	***Removed. Please refer to MAA's Nondurable Medical Supplies and Equipment (MSE) Billing Instructions.***		
0121E	***Removed. Please refer to MAA's Nondurable Medical Supplies and Equipment (MSE) Billing Instructions.***		
0123E	***Removed. Please refer to MAA's Nondurable Medical Supplies and Equipment (MSE) Billing Instructions.***		
0124E	***Removed. Please refer to MAA's Nondurable Medical Supplies and Equipment (MSE) Billing Instructions.***		
A4630	***Removed. Please refer to MAA's Nondurable Medical Supplies and Equipment (MSE) Billing Instructions.***		
A4595	***Removed. Please refer to MAA's Nondurable Medical Supplies and Equipment (MSE) Billing Instructions.***		
A4558	***Removed. Please refer to MAA's Nondurable Medical Supplies and Equipment (MSE) Billing Instructions.***		

Procedure Code	Description	Rental (RR)	Purchase (1P)
0126E	***Removed. Please refer to MAA's Nondurable Medical Supplies and Equipment (MSE) Billing Instructions.***		
E0747	Osteogenesis stimulator, electrical noninvasive, other than spinal applications. **Purchase only**. **(See criteria for prior authorization requirements.)**		$3,603.26
E0748	Osteogenesis stimulator, electrical noninvasive, spinal applications. **Purchase only**. **(See criteria for prior authorization requirements.)**		$3,579.91

Communication Devices

Procedure Code	Description	Rental (RR)	Purchase (1P)
0232E	***Discontinued with dates of service on and after November 1, 2002.***		
0233E	***Discontinued with dates of service on and after November 1, 2002.***		
0209E	***Discontinued with dates of service on and after November 1, 2002.***		
0210E	***Discontinued with dates of service on and after November 1, 2002.***		
0211E	***Discontinued with dates of service on and after November 1, 2002.***		
0213E	***Discontinued with dates of service on and after November 1, 2002.***		
0234E	***Discontinued with dates of service on and after November 1, 2002.***		
K0541	Speech generating device, digitized speech, using pre-recorded messages, less than or equal to eight minutes recording time. **Purchase only. Requires prior authorization.**		$389.13
K0542	Speech generating device, digitized speech, using pre-recorded messages, greater than 8 minutes recording time. **Purchase only. Requires prior authorization.**		$1,504.03
K0543	Speech generating device, synthesized speech, requiring message formulation by spelling and access by physical contact with the device. **Purchase only. Requires prior authorization.**		$3,558.93

Procedure Code	Description	Rental (RR)	Purchase (1P)
K0544	Speech generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access. **Purchase only. Requires prior authorization.**		$6,734.78
K0546	Accessory for speech generating device, mounting system (rigid). **Purchase only. Requires prior authorization.**		$416.93
K0547	Accessory for speech generating device, not otherwise classified. **Purchase only. Requires prior authorization.**		B.R.
0100E	Artificial larynx, complete with battery, charger and carrying case. **Purchase only.**		$594.15
0110E	***Discontinued with dates of service on and after November 1, 2002.***		

Ambulatory Aids

Procedure Code	Description	Rental (RR)	Purchase (1P)
E0100	Cane; includes canes of all materials; adjustable or fixed, with tip. Included in nursing facility daily rate. **Purchase only**.		$21.52
E0105	Cane, quad or three-prong; made of all materials; adjustable or fixed, with tip. Included in nursing facility daily rate. **Purchase only**.		$50.17
E0110	Crutches, forearm; various materials, adjustable or fixed; with tips/handgrips; pair Included in nursing facility daily rate. **Purchase only**.		$79.27
E0111	Crutches, forearm, all materials, each. Included in nursing facility daily rate. **Purchase only**.		$54.41
E0112	Crutches, underarm, wood, adjustable or fixed, per pair, with pads, tips/handgrips. Included in nursing facility daily rate. **Purchase only.**		$37.80
E0113	Crutch, underarm; wood; adjustable or fixed; each, with pad, tip and handgrip. Included in nursing facility daily rate. **Purchase only**.		$21.59
E0114	Crutches, underarm; aluminum; adjustable or fixed; per pair, with pads, tips and handgrips. Included in nursing facility daily rate. **Purchase only**.		$45.47
E0116	Crutch, underarm; aluminum; adjustable or fixed; each, with pad, tip and handgrip. Included in nursing facility daily rate. **Purchase only**.		$24.33
A4635	Underarm pad, crutch, replacement, each. Included in nursing facility daily rate **Purchase only.**		$5.23
A4636	Handgrip, cane, crutch, or walker. Included in nursing facility daily rate. **Purchase only.**		$4.30

10. **Is Patient's Condition Related To**: Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: Primary insurance. When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and MAA pays as payor of last resort.

11a. Insured's Date of Birth: Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3*.

11b. Employer's Name or School Name: Primary insurance. When applicable, enter the insured's employer's name or school name.

11c. Insurance Plan Name or Program Name: Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. Is There Another Health Benefit Plan?: Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a.-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. If **11d.** is left blank, the claim may be processed and denied in error.

17. Name of Referring Physician or Other Source: When applicable, enter the referring physician or Primary Care Case Manager name.

17a. I.D. Number of Referring Physician: When applicable, 1) enter the seven-digit, MAA-assigned identification number of the provider who *referred or ordered* the medical service; OR 2) when the Primary Care Case Manager (PCCM) referred the service, enter his/her seven-digit identification number here. If the client is enrolled in a PCCM plan and the PCCM referral number is not in this field when you bill MAA, the claim will be denied.

19. Reserved For Local Use: When applicable, enter indicator **B** to indicate *Baby on Parent's PIC*. Please specify *twin A or B, triplet A, B, or C* here.

21. Diagnosis or Nature of Illness or Injury: When applicable, enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4. A valid ICD-9-CM code will be required. MAA no longer allows the use of an unspecified/ dummy diagnosis code such as V58.9.

22. **Medicaid Resubmission**: When applicable. If the billing is resubmitted beyond the 365-day billing time limit, you must enter the ICN to verify that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.)

23. **Prior Authorization/EPA Number**: When applicable. If the service or equipment you are billing for requires authorization, enter the nine-digit number assigned to you. Use only one authorization number per claim.

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form**.

MAA does not accept "continued" claim forms. Each claim form must be totaled separately.

24A. **Date(s) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., November 4, 2002 = 110402). **Do not use slashes, dashes, or hyphens to separate month, day, year.**

24B. **Place of Service**: Required. These are the only appropriate code(s) for this billing instruction:

Code Number	To Be Used For
4	Client's residence
7	Nursing facility (formerly ICF)
8	Nursing facility (formerly SNF)
9	Other

24C. **Type of Service**: Required. Enter a **9**.

24D. **Procedures, Services or Supplies HCPCS**: Required. Enter the appropriate Centers for Medicare and Medicaid (CMS) (formerly known as HCFA) Common Procedure Coding System (HCPCS) or state-unique procedure code for the services being billed. **MODIFIER:** When appropriate enter a modifier.

24E. **Diagnosis Code**: Required. Enter the ICD-9-CM diagnosis code related to the procedure or service being billed (for each item listed in 24D). A diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM. A valid ICD-9-CM code is required. MAA no longer allows the use of an unspecified/dummy diagnosis code such as V58.9.

24F. **$ Charges**: Required. Enter your usual and customary charge for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax. Sales tax is automatically calculated by the system and included with your remittance amount.

24G. **Days or Units**: Required. Enter the total number of days or units (up to 999) for each line. These figures must be whole units.

25. **Federal Tax I.D. Number: Leave this field blank.**

26. **Your Patient's Account No.**: Not required. Enter an alphanumeric ID number, i.e., a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Account Number*.

28. **Total Charge**: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

MAA does not accept "continued" claim forms. Each claim form must be totaled separately.

29. **Amount Paid**: If you receive an insurance payment or client-paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not use dollar signs or decimals in this field or put Medicare payment here.

30. **Balance Due**: Required. Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.

33. **Physician's, Supplier's Billing Name, Address, Zip Code and Phone #**: Required. Put the *Name, Address,* and *Phone #* on all claim forms.

P.I.N. #: Required. Enter the individual provider number assigned to you by MAA.